

EDMUND G. BROWN JR., Attorney General
of the State of California
MARGARET A. LAFKO
Supervising Deputy Attorney General
SUSAN FITZGERALD, State Bar No. 112278
Deputy Attorney General
California Department of Justice
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2066
Facsimile: (619) 645-2061

Attorneys for Complainant

**BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the Accusation Against:

Case No. *2008-13*

JAMIE COLLEEN MEYER, RN
909 Georgia Street #4
Huntington Beach, CA 92648

A C C U S A T I O N

Registered Nurse License No. 605013

Respondent.

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 21, 2002, the Board of Registered Nursing issued Registered Nurse License Number 605013 to Jamie Colleen Meyer, RN (Respondent). The Registered Nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2008, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws of the Business and Professions Code:

A. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

B. Section 2761 of the Code states in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

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C. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

4. This Accusation also refers to Title 16, California Code of Regulations section 1443 that states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

CHARGES AND ALLEGATIONS

5. On or about December 31, 2002 RMH, a 61-year old male, went to the emergency room at Riverside Community Hospital in Riverside county, California with a complaint of rapid heart beat (tachycardia). After examination he was admitted for evaluation for shortness of

1 breath and tachycardia.

2 6. On the morning of January 4, 2003, RMH underwent a cardiac catheterization
3 procedure through the femoral artery which resulted in a hematoma in the right groin area. The
4 hematoma was drained but observed to enlarge again. After consultation with another surgeon,
5 the surgeon who had performed the catheterization requested the patient be transferred to the ICU
6 unit. The transfer to the Medical ICU unit occurred at approximately 1530 hours.

7 7. Before transfer to the Medical ICU unit, RMH's blood pressure was dropping and
8 the nursing staff received an order for 500cc normal saline "wide open" and to start a Dopamine
9 drip at 5 mics per minute.

10 8. Between 1430 and 1500 hours, the charge nurse for the Medical ICU unit was told
11 the patient had an arterial bleed in the groin and required Dopamine to try to help maintain the
12 blood pressure. The charge nurse was not informed and did not seek out any further medical
13 information or history on the patient except that the hematoma/thigh measurement was 27 inches.

14 9. From admission to the Medical ICU until 1900 hours, when the charge nurse's
15 shift ended and the patient's care was turned over to Respondent and her RN preceptor, RMH's
16 blood pressure continued to fall slowly and the Dopamine drip was increased to 7 mics per
17 minute at around 1900 hours, except that at approximately 1800 hours the charge nurse noted a
18 rapid change in RMH's blood pressure while lying on his side. The charge nurse returned the
19 patient to a supine position.

20 10. As of 1900 hours, Respondent was the nurse who provided the care for RMH,
21 although Respondent's preceptor RN was also on the unit and received the report, along with
22 Respondent, from the charge nurse who went off duty at 1900 hours.

23 11. At around 2100 hours, the Dopamine was changed to double strength and the
24 infusion pump rate was decreased from 32cc/hour to 16cc/hour. At that time, Respondent noted
25 only 50cc of urine output.

26 12. Per Respondent's notes from 2000-2330 hours, RMH became progressively more
27 restless and continued to try to find a comfortable position; the EKG strips showed a significant

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1 change in rhythms indicative of hypovolemia (diminished blood supply); and the patient's breath
2 sounds became coarser.

3 13. Respondent did not make any physician aware of the cardiac changes. She did
4 report the decreased urine output and the coarse breath sounds. Lasix was ordered and
5 administered by IV push.

6 14. From 2330 hours of January 4, 2003 to 0016 hours of January 5, 2003, RMH's
7 blood pressure continued to fall and his respiratory effort became diminished. Respondent
8 decreased the IV fluids from 150cc/hour to TKO and repositioned the patient to obtain a more
9 accurate blood pressure. At around this time Respondent noted a decrease in the patient's
10 respiratory effort and paged the attending physician. A code was called at 2355 hours. The
11 patient died at 0016 hours of hemorrhagic shock from a laceration of the femoral artery and the
12 resultant hematoma.

13 CAUSE FOR DISCIPLINE

14 (Unprofessional Conduct: Incompetence)

15 15. Respondent is subject to disciplinary action under section 2761(a)(1) for
16 unprofessional conduct, to wit incompetence, as more particularly alleged in paragraphs 5-14
17 above and incorporated herein by reference and as below:

18 A. Respondent lacked the knowledge and skill as an ICU nurse to identify that the
19 patient was already going into hypovolemic shock even at the beginning of
20 Respondent's shift;

21 B. As Respondent's shift progressed, she was unable to adequately recognize the
22 progression of signs and symptoms toward cardiogenic shock.

23 PRAYER

24 WHEREFORE, Complainant requests that a hearing be held on the matters herein
25 alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

26 1. Revoking or suspending Registered Nurse License Number 605013, issued to
27 Jamie Colleen Meyer, RN;

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1 2. Ordering Jamie Colleen Meyer, RN to pay the Board of Registered Nursing the
2 reasonable costs of the investigation and enforcement of this case, pursuant to Business and
3 Professions Code section 125.3;

4 3. Taking such other and further action as deemed necessary and proper.

5 DATED: 7/9/07

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8 *Ruth Ann Terry* for
RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant
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